Laughing Buddha Community Acupuncture, LLC
970.309.9253
www.laughingbuddha-acupuncture.com

Dear New Patient,

Welcome! Thank you for your interest in acupuncture and Oriental medicine. At Laughing Buddha Community Acupuncture, LLC, we do our best to assure that you receive the best quality care. We want you to know that we are committed to:

- Making sure that our customer service always meets the highest standards.
- Making sure that any questions you have about your care are answered in a way that you can understand.
- Making sure that your phone calls are returned promptly.
- Making sure that your private health care information is kept secure and private.

Enclosed you will find several forms. Please fill them out and bring the forms along with you to your first appointment. If you have any questions about these forms, please call us at 970.309.9253 and we will be happy to help you.

Again, welcome to Laughing Buddha Community Acupuncture. You have taken an important step on the road to more vibrant health. We look forward to serving you.

Sincerely yours,

Susan Engle, L.Ac., MSOM
Laughing Buddha Community Acupuncture, LLC
236 West 3rd Street
Eagle, CO 81631
970.309.9253

Laughing Buddha Community Acupuncture, LLC
Susan Engle, MSOM, LAc
Patient Health History

Name: ____ Date: ______/______/______

Address: ____

Contact Phone #: ______________________________________ (Can we contact you at this number?) Y / N

Email: ____

Would you like to receive future emails and newsletters? Yes / No

Date of Birth: ______/______/______ Age: _________ Gender: M / F

Height: _________ Weight: ________ Marital Status: ____________________

Physician: _______________________________ Referred to this office by: __________________

In Emergency, Notify: ____________________________ Relationship: ______________________

Emergency Phone #: ____________________________ Had acupuncture previously? Y / N

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Please print all information and indicate areas of confusion with a question mark. Thank you.

1. What is your primary concern, condition, injury or illness?______________________________________

____

How long has it bothered you?____

Describe what caused it/how it started:____

____

How does this condition affect you? (Interference with work, sleep, appetite, etc.)___________________

____

Have you received treatment for this condition?______________ When?____________________________

From Whom?______________________Diagnosis?____

Has the condition gotten: Better ______________ Worse _____________ Same ______________

2. List all medications taken within the last two months (vitamins, drugs, herbs, etc.): _______________

____

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction): ____

4. Do you have any reason to believe you may be pregnant? Y / N

If so, how far along are you? ____

5. What is your most recent blood pressure reading? _______/_______ Reading Dated? _____________

6. Do you have any infectious diseases? Y / N If yes, please identify: _____________________

7. **Childhood Illness** (please circle any that you have had): Chicken Pox Mumps
Scarlet Fever Diphtheria Rheumatic Fever Measles German Measles

8. **Immunizations** (please circle any that you have had): Polio Tetanus
Rubella/Mumps/Rubella Pertussis Diphtheria Hepatitis B Other: ____________________

9. **Hospitalizations and Surgeries:**

Reason	When	Reason	When

10. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When

11. **Family History:**
Check those applicable:

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health (G=Good, P=Poor)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						
Asthma/Hay fever/Hives						
Kidney Disease						
Age (at death)						
Cause of Death						

12. Have you experienced any major traumas? Y / N Explain: ____________________

13. Please put a check next to conditions that you have experienced **within the last three months**. Indicate the length of time you have had this condition:

GENERAL:

☐ Poor Appetite ☐ Insomnia ☐ Disturbed Sleep

☐ Localized Weakness ☐ Cravings ☐ Strong Thirst

☐ Weight Gain ☐ Weight Loss ☐ Changes in Appetite

☐ Sweating Easily ☐ Tremors ☐ Bleed or Bruise Easily

☐ Night Sweats ☐ Fever ☐ Chills

☐ Poor Balance ☐ Sudden Energy Drop (time of day?) ____________________

☐ Other unusual or abnormal conditions you have noticed in your general sense of health? __________

____

SKIN & HAIR:

☐ Rashes ☐ Ulcerations ☐ Hives

☐ Itching ☐ Eczema ☐ Pimples

☐ Dandruff ☐ Hair Loss ☐ Recent Moles

☐ Changes in hair or skin texture ____

Any other hair or skin problems? ____

HEAD, EYES, EARS, NOSE, THROAT:

☐ Dizziness ☐ Concussions ☐ Migraines

☐ Headaches (where/when?) ____

☐ Glasses/Contacts ☐ Spots in Front of Eyes ☐ Eye Tearing/Dryness

☐ Poor Vision ☐ Night Blindness ☐ Color Blindness

☐ Cataracts ☐ Blurry Vision ☐ Earaches

☐ Ringing in Ears ☐ Poor Hearing ☐ Eyestrain

☐ Sinus Problems ☐ Recurrent Sore Throat ☐ Nose Bleeds

☐ Grinding Teeth ☐ Sores on Lips/Tongue ☐ Facial Pain

☐ Teeth Problems ☐ Jaw Clicks ☐ Other ______________

CARDIOVASCULAR:

☐ Pacemaker ☐ Chest Pain/Discomfort ☐ Heart Murmur

☐ Irregular Heartbeat ☐ High Blood Pressure ☐ Low Blood Pressure

☐ Fainting ☐ Palpitations/Fluttering Heart ☐ Varicose Veins

☐ Blood Clots ☐ Swelling of Hands/Feet ☐ Cold Hands/Feet

☐ Stroke ☐ Rheumatic Fever ☐ Other ______________

RESPIRATORY:

☐ Persistent Cough ☐ Coughing up Blood ☐ Asthma/Wheezing

☐ Shortness of Breath ☐ Emphysema ☐ Pneumonia

☐ Bronchitis ☐ Catch Common Cold Easily ☐ Tuberculosis

☐ Difficulty Breathing ☐ Pain with Breathing ☐ Pleurisy

☐ Production of Phlegm (color?) __________________________ ☐ Other ______________

GASTROINTESTINAL:

☐ Change in Appetite ☐ Weight Gain/Loss ☐ Anorexia Nervosa/Bulimia

☐ Nausea ☐ Vomiting ☐ Diarrhea or Loose Stool

☐ Constipation ☐ Gas ☐ Belching

☐ Diarrhea or Loose Stool ☐ Blood in Stools ☐ Pain with Passing Stool

☐ Black Stool ☐ Pale Stool ☐ Strong Smelling Stool

☐ Bad Breath ☐ Rectal Pain ☐ Hemorrhoids

☐ Abdominal Pain/Cramps ☐ Ulcers ☐ Hepatitis B or C

☐ Gallbladder Disease ☐ Liver Disease ☐ Other

MUSCULOSKELETAL:

☐ Neck Pain ☐ Muscle Spasms/Cramps ☐ Knee Pain

☐ Back Pain ☐ Muscle Weakness ☐ Foot/Ankle Pain

☐ Hand/Wrist Pain ☐ Shoulder Pain ☐ Hip Pain

Any other joint/bone problems? ______________________________

GENITO-URINARY:

☐ Pain on Urination	☐ Frequent Urination	☐ Blood in Urine
☐ Urgency to Urinate	☐ Heavy Flow	☐ Incontinence
☐ Kidney Disease	☐ Kidney Stones	☐ Frequent UTI
☐ Decrease in Flow	☐ Impotence	☐ Sores on genitals

Do you wake up at night to urinate? _________ If so, how often? _________

Any particular color to your urine? __________________________________ ☐ Other

ENERGY AND IMMUNITY:

☐ Fatigue	☐ Slow Wound Healing	☐ Bruise Easily
☐ Get Sick Easily	☐ Chronic Fatigue Syndrome	☐ Chronic Infections

NEUROPSYCHOLOGICAL:

☐ Seizures/Epilepsy	☐ Loss of Balance/Coordination	☐ Paralysis
☐ Vertigo	☐ Dizziness	☐ Numbness/Tingling
☐ Poor Memory	☐ Nervousness	☐ Mood Swings
☐ Anxiety/Fear	☐ Depression	☐ Bad Temper
☐ Panic Attacks	☐ Easily Susceptible to Stress	☐ Other

Have you ever been treated for emotional problems? Y / N

Have you ever considered or attempted suicide? Y / N

FEMALE REPRODUCTIVE/BREASTS:

☐ Menstrual Clots ☐ Painful Menses ☐ Irregular Menses

☐ Changes in body/psyche prior to menstruation _____________________ Duration _________________________

☐ Bleeding Between Cycles	☐ Heavy Flow	☐ Breast Lumps/Tenderness
☐ Nipple Discharge	☐ Vaginal Discharge	☐ Frequent Vaginal Infections
☐ Vaginal Itching/Irritation	☐ Vaginal Odor	☐ Painful Intercourse
☐ Difficulty Conceiving	☐ Low Libido	☐ Other

MENSTRUAL/BIRTHING HISTORY:

Age at 1st Menses ________________	Days between Menses ____________	# Days of Flow ___________________
First day of last Menses ___________	# Pregnancies ___________________	# Live Births _____________________
# Miscarriages __________________	# Abortions _____________________	# Premature Births _______________
Birth Control? ___________________	If so, type? _____________________	How Long? _______________________
Date of Last PAP ________________	☐ Menopause (Age) _____________	☐ Other

MALE REPRODUCTIVE:

☐ Prostate Problems ____________ ☐ Testicular Pain/Swelling ________ ☐ Penile Discharge _______________

☐ Sexual Difficulties (explain) ____

ENDOCRINE:

☐ Hypothyroid __________________	☐ Hyperthyroid _________________	☐ Hypoglycemia _________________
☐ Diabetes Mellitus ______________	☐ Night Sweats _________________	☐ Feeling Hot or Cold _____________

OTHER:

☐ Anemia ______________________ ☐ Cancer ______________________

Is there anything else we should know? _______________________________

LIFESTYLE:

14. Do you follow a regular exercise program? ____

15. How many hours per night do you sleep? _________ Do you wake rested? Y / N

16. Please describe your average daily diet:

Morning: ____

Afternoon: ____

Evening: ____

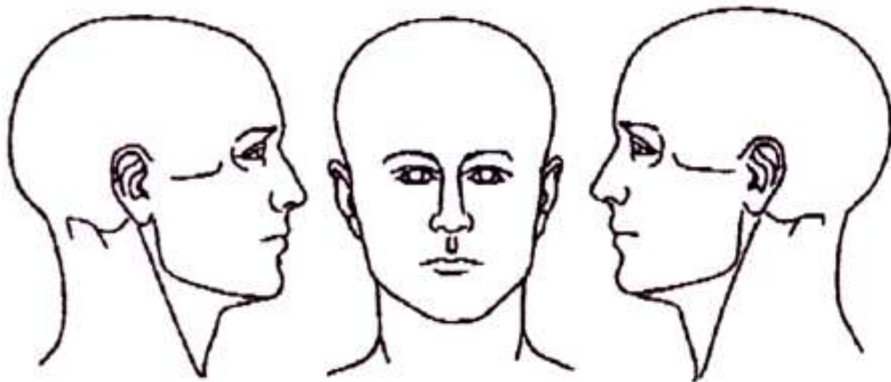
17. Please indicate usage per day or per week:

Cigarettes ____________________per Day/Week/Month   Tea __________________per Day/Week/Month
Alcohol ______________________per Day/Week/Month   Soft Drinks ___________per Day/Week/Month
Drugs ________________________per Day/Week/Month   Sugar ________________per Day/Week/Month
Coffee _______________________per Day/Week/Month   Water ________________per Day/Week/Month

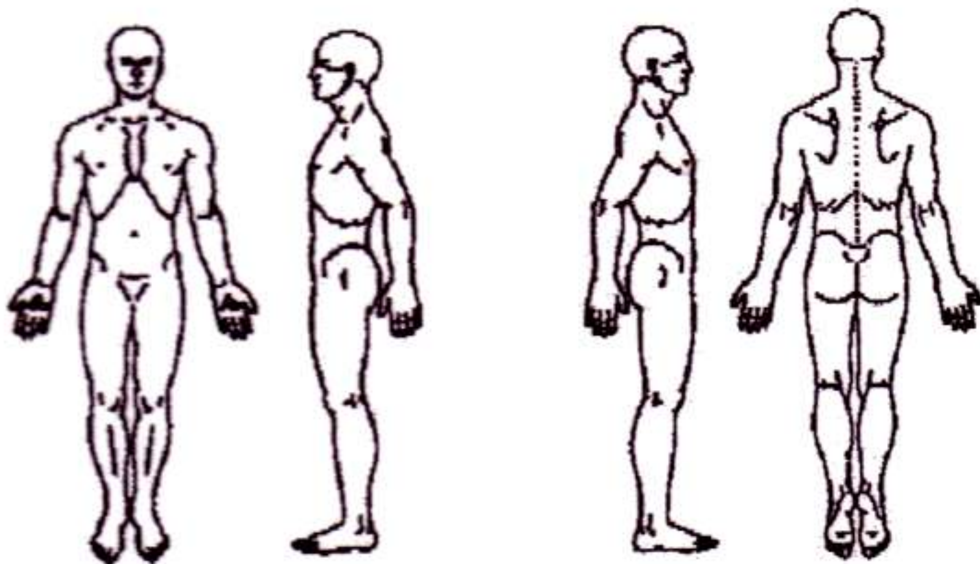
18. Education completed: High School   Bachelors   Masters   Doctorate
19. Occupation: ______________________Employer: ___________________________ Hrs/week: ___________
Do you enjoy work?   Y / N   Why/ Why Not? ____

20. Interests/Hobbies: ____

INDICATE PAINFUL OR DISTRESSED AREAS:



FRONT   **LEFT**   **RIGHT**   **BACK**



Financial Policies/Payments

Payment is expected in full at time of service. We accept cash, check and most major credit cards. We offer a $5 discount on all treatments paid for by cash or personal check.

There is a $25 fee for returned checks, with an additional $25 fee charged each additional week that the account is not cleared of the bad check.

Insurance Billing
We do not bill insurance. Upon request, an invoice can be produced which may be submitted to insurance companies for reimbursement by the patient. Please ask for this invoice at time of payment.

Laughing Buddha Community Acupuncture, LLC does not guarantee reimbursement by the patient's insurance company.

I understand that it is not the responsibility of Laughing Buddha Community Acupuncture, LLC to research whether reimbursement may occur, to submit forms for reimbursement, or to follow-up with my insurance company regarding reimbursement.

Cancellation Policy
Laughing Buddha Community Acupuncture, LLC requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. Missed appointments without notification and cancellations with less than 24 hours notice will be charged the full fee visit.

- I agree to pay for services rendered at time of service. I acknowledge that I may request the fees for various procedures before they may occur and include that information in my decision regarding health care.
- I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- I consent to treatment as agreed upon between the practitioner and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the practitioner.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

______________________________________ ______________________
Signature of Patient or Authorized Representative Date

______________________________________ ______________________
Printed Name and relationship to patient Date of Birth